7.12: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.6 CMR 7.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.6 CMR 7.00.

7.13: Severability

The provisions of 114.6 CMR 7.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 7.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.6 CMR 7.00: M.G.L. c. 118G, §§ 6(a) and 15 as amended by St. 1995, c. 38.

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 9: 117 CMR 9.00
G.L. c.151A §14G

117 CMR 9.00: MEDICAL SECURITY PLAN

Section

9.01: General Provisions

(1) Name, Scope, Purpose, and Effective Date.

(a) The health care for the unemployed program described in 117 CMR 9.00 shall be known as the "Medical Security Plan" ("MSP").

(b) 117 CMR 9.00 implements the provisions of M.G.L. c. 118F, as most recently amended by St. 1995, c. 38 regarding health insurance benefits for the unemployed.

(c) The purpose of 117 CMR 9.00 is to provide basic medical security for those eligible residents of the Commonwealth of Massachusetts who are receiving benefits or are eligible to receive benefits under M.G.L. c. 151A, and their dependents.

(2) Authority. 117 CMR 9.00 is adopted pursuant to M.G.L. c. 118F as most recently amended by St. 1995, c. 38.

(3) Organization. 117 CMR 9.00 is divided into sections. Each section may be further divided into subsections designated by Arabic numerals enclosed in parenthesis. A subsection may be segregated into divisions, designated by letters enclosed in parenthesis. A division may be further segregated into subdivisions designated by Arabic numerals followed by a period.

9.02: Definitions

The following words and phrases as used in 117 CMR 9.00 have the following meanings unless otherwise clearly indicated by their context:

An Appellant is a Medical Security Plan recipient who has initiated a proceeding under 117 CMR 9.11(3)(a).

An Applicant is a person submitting an application for benefits provided under 117 CMR 9.00.

The Base Period and Benefit Year are as defined in M.G.L. c. 151A, §§ 1(a) and (c), respectively.

Benefits are either the Direct Coverage Plan or the Premium Assistance Plan.

The Commissioner is the Commissioner of the Department of Medical Security or his or her designee.

A Continued Health Insurance Plan is a health insurance plan or self-insurance health plan, except the Medicare program:

(a) for which the primary enrollee is legally obligated to pay and pays the full cost of his or her premium; and

(b) in which the primary enrollee participated at the time of, or prior to, applying for unemployment compensation benefits, including persons whose continued eligibility is based on federal COBRA law.

9.02: continued

A Contract Unit is an individual or family which submits a single application and receives benefits under 117 CMR 9.00.

A Dependent is as defined in M.G.L. c. 118F, § 2.

The Department is the Department of Medical Security or its designee.

The Direct Coverage Plan is a health plan in which the Department makes contributions toward the cost of covered health care services utilized by the enrollee. The extent and terms of the plan shall be set forth in the Department's benefits schedule. The benefits schedule shall be available to the public and shall be subject to change from time to time. Applicants qualifying for the Premium Assistance Plan shall be ineligible for enrollment in this plan.

An Enrollee is a person who, either individually or as a member of a family, is receiving benefits under 117 CMR 9.00.

Family Income is the sum of all money, earned or unearned, such as salaries, wages, rents, tips, bonuses and annuities, received by the applicant and his or her dependents.

Family Size is the sum of the number one (representing the applicant), and the number of people who meet the definition of dependent with respect to the applicant.

Hardship exists if expenditures for a Continued Health Insurance Plan have depleted or can reasonably be expected to deplete the financial resources or income of an applicant or primary enrollee to the extent that the applicant or primary enrollee will be unable to pay for needed goods and services to support him or herself and other members of the contract unit. The existence of a hardship shall be determined by the Department.

Health Care Services are as defined in M.G.L. c. 118F, § 2.

A Health Insurance Plan is as defined in M.G.L. c. 118F, § 2.

A Health Plan is a health insurance plan, medical assistance program, a self-insurance health plan, or any other plan or program which provides for payment by a third-party payor or governmental payor for health care services used by the applicant or his or her dependents.

A Medical Assistance Program is as defined in M.G.L. c. 118F, § 2.

The Premium Assistance Plan is a plan in which the Department makes payments directly to the enrollee in order to subsidize the enrollee's continued health insurance plan. An enrollee in the Premium Assistance Plan is reimbursed for a portion of his or her premium cost in accordance with the Department's reimbursement schedule. The reimbursement schedule shall be available to the public and shall be subject to change from time to time. The Premium Assistance Plan does not provide direct payment for the cost of health care services. Payment to or on behalf of an enrollee for health care services is subject to the terms and conditions of the enrollee's continued health insurance plan. Applicants qualifying for benefits under this plan shall be ineligible for enrollment in the Direct Coverage Plan.

Presumptive Hardship. Hardship shall be presumed if:

(a) an applicant is receiving unemployment benefits and his or her actual, available total gross family income is at or under 200% of the current federal non-farm poverty income guidelines; or

(b) an applicant is initially determined ineligible for unemployment compensation benefits by the Department of Employment and Training and meets the following criteria:

1. the applicant's denied unemployment compensation has not been overturned within the first 30 days of his or her claim;
2. the applicant fulfills the conditions in 117 CMR 9.07(2)(c); and
3. the applicant has not maintained his or her federal COBRA coverage.

9.02: continued

A Primary Enrollee is an enrollee who has applied and been approved for benefits under 117 CMR 9.00 on behalf of himself or herself and/or his or her family, following the waiting period if approved for the Direct Coverage Plan.

A person receives Unemployment Compensation Benefits if he or she actually receives a check for any amount of benefits under M.G.L. c. 151A. A person receives unemployment compensation benefits if he or she does not receive a check, but would have received a check if he or she were not having an amount deducted from his or her payments due to:

(a) recovery of erroneous payments, in accordance with M.G.L. c. 151A, § 69; or
(b) withholding of child support obligations, in accordance with M.G.L. c. 151A, § 29B.

A person is eligible for Unemployment Compensation Benefits if he or she meets the eligibility requirements set forth in M.G.L. c. 151A, § 24.

A Resident of the Commonwealth is a person who lives in the Commonwealth with the intent to remain permanently or for an indefinite period.

A Self-Insurance Health Plan is as defined in M.G.L. c. 118F, § 2.

A Third-Party Payor is as defined in M.G.L. c. 118F, § 2.

Unemployment Compensation is the program authorized by M.G.L. c. 151A.

Waiting Period is a 60 consecutive-day waiting period before benefits are available. A contract unit may be eligible for immediate benefits during the waiting period for certain emergency conditions as described in the Department's benefits schedule.

A Week is seven consecutive days beginning on Sunday.

9.03: Eligibility Requirements

(1) Applicant. In order to be eligible for benefits under 117 CMR 9.03 an applicant must meet all of the following requirements:

(a) Receive or be Eligible to Receive Unemployment Compensation Benefits. An applicant must receive unemployment compensation benefits under the provisions of M.G.L. c. 151A, including extended benefits under M.G.L. c. 151A, § 30A or extended benefits under any federal act, to which he or she is entitled within the benefit period defined in 117 CMR 9.07(2), or be eligible to receive unemployment benefits pursuant to the provisions of M.G.L. c. 151A, § 24.

(b) Employment in Massachusetts. An applicant must receive unemployment compensation in whole or in part for employment by an employer subject to the provisions of M.G.L. c. 151A, §§ 8, 8A, 8B, or 8C.

(c) Residence. An applicant must be a resident of the Commonwealth of Massachusetts.

(d) Maximum Family Income.

1. An applicant must not have family income greater than 400% of the federal non-farm poverty level as established by the United States Department of Management and Budget for a family of that family size. The poverty level shall be the level in effect for the calendar year in which the last day of the applicant becomes unemployed. If the poverty level for that year has not been published in the Federal Register on that date the poverty level shall be the poverty level of the prior year. The Department may change the income requirements from time to time.

2. For MSP Elibibility total family income is calculated as the gross income of the applicant and the applicant's spouse, if any, in the six months prior to application, and a projection of the gross income of the applicant and the applicant's spouse, if any, including a calculation of the maximum benefits payable to the applicant and the applicant's spouse, if any, from unemployment benefits and extended benefits, for the six months after application.

3. For purposes of determining total family income under the hardship provisions as defined in 117 CMR 7.02, total family income shall be calculated as the gross income of the applicant and the applicant's spouse, if any, in the 12 months prior to the request for a hardship determination.

9.03: continued

(e) Alternative Health Plan. An applicant must not be enrolled in a health plan unless such a plan is a continued health insurance plan.

(f) Release.

1. An applicant must execute in writing a release of information from the Department of Employment and Training to the Department. The release shall permit the Department of Employment and Training to provide the Department with information concerning the applicant that is necessary for the proper administration of 117 CMR 9.03. The applicant must execute the release in a manner prescribed by the Department.

2. An applicant must execute in writing a release of information from the provider of health care services or other party to the Department as is necessary for the proper administration of 117 CMR 9.03. The applicant must execute the release in the manner prescribed by the Department.

(2) Other Members of the Contract Unit. In order to be and remain eligible for membership in the contract unit, a person other than the applicant must:

(a) be a dependent of the applicant;

(b) be a resident of the Commonwealth of Massachusetts;

(c) not be enrolled in a health plan unless such a plan is a continued health insurance plan; and

(d) be a person who has the legal capacity to execute an assignment referred to in 117 CMR 9.08(3) and the release referred to in 117 CMR 9.03(1)(f)2.

(3) Primary Enrollee. In order for a contract unit to remain eligible for benefits under 117 CMR 9.03, the primary enrollee must continue to meet all of the following requirements:

(a) Receive or Eligible to Receive Unemployment Compensation Benefits. The primary enrollee satisfies this requirement for a given week if the primary enrollee receives or is eligible to receive unemployment compensation benefits for that week.

(b) Residence. The primary enrollee must be a resident of the Commonwealth of Massachusetts.

(c) Alternative Health Plan. The primary enrollee must not be enrolled in a health plan unless such a plan is a continued health insurance plan.

(d) Notification of Changed Circumstances. The primary enrollee must notify the Department within seven days after any change of information which was reported or required to be reported on the application. This requirement of notification shall include, but not be limited to, termination of dependency status, change of residence, and change of employment status.

9.04: Initial Application Procedure

(1) Written Application. All applicants must submit a signed, written application for benefits in a manner determined by the Department.

(2) Election of Plan. All applicants who are enrolled in a continued health plan at the time of application for benefits, must maintain continued enrollment in the health insurance plan in which they were enrolled prior to applying for unemployment compensation benefits, or as permitted by federal COBRA law. Such applicants shall be ineligible for enrollment in the Direct Coverage Plan and must elect the Premium Assistance Plan on their application. The Department may require applicants to submit proof demonstrating their ineligibility for the Premium Assistance Plan.

(3) Exceptions.

(a) Applicants who do not qualify for COBRA benefits through their former employer or their spouse's employer shall be eligible for the Direct Coverage Plan pursuant to the eligibility requirements of 117 CMR 9.00.

(b) Applicants unable to maintain continued enrollment in the health insurance plan in which they were enrolled prior to applying for unemployment compensation benefits may be eligible for the Direct Coverage Plan if:

9.03: continued

1. the Department determines that a hardship exists as defined in 117 CMR 9.02: or
2. an applicant meets the requirements of a presumptive hardship as defined in 117 CMR 9.02.

(4) Verification. All applicants must include with their application adequate verification of the facts necessary to establish eligibility. An application shall not be considered complete until all necessary verification documents have been supplied by the applicant. The documents necessary to verify eligibility shall be determined by the Department.

9.05: Other Application Procedures

(1) Reinstatement of Coverage. A former primary enrollee with his or her contract unit, subsequent to a period of temporary ineligibility, will be reinstated :

(a) If the period of temporary ineligibility was due solely to the failure to satisfy the requirements of 117 CMR 9.03(3)(a), and the period of ineligibility was 90 days or less, the primary enrollee need not re-apply but must submit verification of eligibility within the 90 day period, in order to be reinstated. The documents necessary to verify the period of eligibility shall be determined by the Department.

(b) In all circumstances other than those described in 117 CMR 9.05(1), the primary enrollee must submit a signed, written re-application as prescribed by the Department.

(2) Completion of the Benefit Year. A primary enrollee who has completed his or her benefit year and desires to resume receipt of benefits for his or her contract unit subsequent to a period of ineligibility must submit a signed, written application as prescribed in 117 CMR 9.04, and may not follow the procedures set forth in 117 CMR 9.05(1).

(3) Change of Benefit Plan. A primary enrollee who wishes to change from the Premium Assistance Plan to the Direct Coverage Plan, or from the Direct Coverage Plan to the Premium Assistance Plan, must submit a signed, written, notification in the manner prescribed by the Department. The primary enrollee may change from the Premium Assistance Plan to the Direct Coverage Plan if he or she discontinues enrollment or is terminated from enrollment in his or her continued health insurance plan.

(4) Change of Membership of the Contract Unit. A primary enrollee who wishes to add or remove a person from his or her contract unit must submit a signed, written notification in a manner prescribed by the Department.

9.06: Determination

(1) Initial Application. The Department shall determine whether the applicant and the named dependents meet the eligibility requirements. The Department shall first determine whether the applicant is eligible for benefits under 117 CMR 9.06. The Department shall begin processing applications within five working days and shall determine eligibility with reasonable promptness after it has received a completed application and verification from the Department's designee that the applicant is receiving unemployment compensation benefits.

(a) If the applicant is found to be ineligible, the entire contract unit shall be determined ineligible.

(b) If the applicant is found to be eligible, the Department shall then determine the eligibility of each dependent. The applicant, along with all eligible dependents, shall constitute the contract unit.

(2) Other Applications and Requests. The Department shall act upon the applications and notifications as set forth in 117 CMR 9.05 with reasonable promptness after it has received a completed application.

(a) If the Department is unable to make a determination of eligibility because the application or signed written notification is incomplete, the Department will contact the applicant in writing or by telephone to request the necessary information.

(b) If the applicant fails to adequately respond to the Department's request within 21 days after the date of such notice, the application or request to change benefit plans shall be denied.

9.06: continued

(3) Notification. The Department shall promptly notify the applicant in writing of its determination once such a determination is made if the application is denied in whole or in part. The notification shall contain the reason for denial and information regarding grievance and appeal procedures.

9.07: Benefits

(1) General. A contract unit may receive the Direct Coverage Plan or the Premium Assistance Plan as defined in 117 CMR 9.02 and pursuant to the requirements in 117 CMR 9.04.

(2) Period of Benefits

(a) Direct Coverage Plan. A contract unit under the Direct Coverage Plan shall be eligible for benefits following the waiting period as set forth in 117 CMR 9.02. The waiting period shall begin on the date a completed application is received by the Department or its designee or on the date when every member of the contract unit satisfies all eligibility criteria, whichever is later. A contract unit shall continue to be eligible for benefits for all weeks subsequent to the waiting period during which every member of the contract unit met or meets the eligibility criteria set forth in 117 CMR 9.03.

(b) Premium Assistance Plan. A contract unit under the Premium Assistance Plan shall be eligible for benefits retroactive to the first day on which every member of the contract unit satisfies all eligibility criteria, or 30 days prior to the date a completed application is received by the Department or its designee, whichever is later. A contract unit shall continue to be eligible for benefits for all weeks subsequent to the initial date of eligibility during which every member of the contract unit met or meets the eligibility criteria set forth in 117 CMR 9.03.

(c) Exception. Notwithstanding the provisions of 117 CMR 9.07(2)(a) and 9.07(2)(b), retroactive benefits shall be granted to a contract unit when all of the following conditions are met:

1. The applicant was determined to be ineligible for unemployment compensation benefits by the Department of Employment and Training at the time the Department of Employment and Training made its initial determination of eligibility; and
2. The applicant was subsequently determined to be eligible for unemployment compensation benefits in accordance with the appeal or redetermination procedures of the Department of Employment and Training; and
3. The applicant applied for benefits under 117 CMR 9.07 within 30 days after the determination described in 117 CMR 9.07(2)(c)2.

If the applicant applies for the Direct Coverage Plan, the contract unit shall be eligible for benefits retroactive to the first day following the conclusion of the waiting period based on the first day of eligibility for unemployment compensation as established through the procedures set forth in 117 CMR 9.07(2)(c)2. or to the first day on which every member of the contract unit satisfies all eligibility criteria, whichever is later.

If the applicant applies for the Premium Assistance Plan, the contract unit shall be eligible for benefits retroactive to the first day on which every member of the contract unit satisfied all eligibility criteria based on the first day of eligibility for unemployment compensation as established through the procedures set forth in 117 CMR 9.07(2)(c)2.

(2) Change of Benefit Plan. A request for change of benefit plan from the Premium Assistance Plan to the Direct Coverage Plan in accordance with 117 CMR 9.04(3) shall be effective:

(a) 60 days after the initial complete application for benefits is received; or
(b) on the date the existence of a hardship is determined by the Department; or
(c) on the date when every member of the contract unit satisfies all eligibility criteria, whichever is later.

(3) Benefits when Contract Unit Changes. Notwithstanding the provisions of 117 CMR 9.07(2), a dependent who is added to a contract unit through the procedure set forth in 117 CMR 9.05(4) shall become a member of the contract unit:

(a) under the Direct Coverage Plan, retroactive to the first day on which the added member satisfies all eligibility criteria or to the effective date of coverage after the waiting period, whichever is later.

9.07: continued

(b) under the Premium Assistance Plan, retroactive to the first day on which the added member satisfies all eligibility criteria or 30 days prior to the date the Department or its designee receives the request for change in membership, or the first day on which the primary enrollee satisfied all eligiblity criteria, whichever is later.

(4) Limitations. Benefits under the Direct Coverage Plan shall not include costs or charges incurred by an enrollee that are reimbursed or reimbursable by a third-party payor or governmental payor. The Department may refuse to make payments on behalf of or to an enrollee who is determined to have alternate sources of payment, including, but not limited to, other governmental programs, any insurance, workers' compensation, and Veteran's Administration programs.

(a) Payment of benefits shall depend upon the enrollee satisfying the managed care requirements of the Department or its designee and claims processing requirements established by the Department.

(b) Payment of benefits shall not be made for services received outside the Commonwealth of Massachusetts except under the following circumstances:

(1) In the judgment of the Department or its designee, services are rendered in an emergency; or

(2) The services are furnished to covered full-time student dependents residing within the United States of America but outside Massachusetts.

(5) Recoupment. The Department is a payor of last resort and accordingly, the Department may seek recovery from an enrollee of any and all amounts paid on behalf of or to an enrollee who is subsequently determined to have been ineligible for benefits under 117 CMR 9.07.

9.07: continued

Under circumstances where the enrollee is determined to have been ineligible for benefits solely because the primary enrollee failed to satisfy the requirements of 117 CMR 9.03(1)(a) or 117 CMR 9.03(3)(a), the Department may seek recovery only if the primary enrollee has no further appeals available to him or her in accordance with M.G.L. c. 151A, §§ 39 through 42. However, the Department shall not seek recovery if the primary enrollee demonstrates that he or she applied for unemployment compensation benefits with a good faith belief that he or she was eligible for unemployment compensation benefits.

The Department may seek recovery against an enrollee or other payee of any and all amounts paid to an enrollee or other payee that were reimbursed or reimbursable under 117 CMR 9.07(5).

9.08: Third Party Payments; Repayment; Assignment; Subrogation

To the extent that the Department is obligated to pay for an enrollee's health care benefits related to an accident, injury, illness, or other loss suffered by the enrollee, the following requirements shall apply:

(1) When any enrollee receives payment from a third party as a result of an accident, injury, illness or other loss suffered by the enrollee, the enrollee shall repay to the Department an amount equal to the benefits provided under the Direct Coverage Plan.

(2) The application for and receipt of Direct Coverage benefits shall, operate as a lien to secure repayment against monies which may be provided by the third party up to the amount of such benefits. An enrollee shall notify any potential third party payor that any liability or obligation by such payor to the enrollee, is subject to a lien by the Department.

(3) If benefits are provided by a third party as a result of an accident, injury, illness or other loss suffered by the enrollee, the Department shall require the enrollee receiving such benefits to assign to the Department in writing, an amount equal to the benefits so provided from the proceeds of any claim against the third party.

(4) An enrollee shall notify the Department in writing of his or her filing of a civil action or other proceeding to establish the liability of any third party or to collect monies payable under any accident or liability insurance, or from any other source by reason of the accident or injury.

(5) The Department shall be subrogated to an enrollee's entire cause of action or right to proceed against any third party and to an enrollee's claim for monies to the extent of assistance provided under 117 CMR 9.00. The Department, with the consent of the attorney general, may, by attorneys employed or selected by it, commence a civil action or other proceeding on behalf of the Department to establish the liability of any third party or to collect such monies.

9.09: Termination of Benefits

If a contract unit or member of a contract unit is subject to termination of benefits for one or more of the reasons set forth in 117 CMR 9.09(1) through (11), the termination shall be effective for the entire contract unit on the earliest date authorized by 117 CMR 9.09.

The primary enrollee of a contract unit whose benefits are terminated shall be notified promptly in writing after such decision. The termination notice shall contain the reason for termination and information regarding grievance and appeal procedures.

An enrollee other than the primary enrollee whose membership in a contract unit is terminated shall be notified promptly in writing after such decision. The termination notice shall contain the reason for termination and information regarding grievance and appeal procedures. A copy of such notice shall also be mailed to the primary enrollee if the primary enrollee resides at a different address.

Benefits shall be terminated under the following circumstances:

9.09: continued

(1) Termination of Unemployment Compensation Benefits. Benefits shall be terminated for the contract unit seven days after the primary enrollee for any reason fails to satisfy the requirements of 117 CMR 9.03(3)(a).

(2) Completion of the Benefit Year. Benefits shall be terminated for the contract unit seven days after the last day of the primary enrollee's benefit year unless the primary enrollee receives unemployment compensation benefits during the final week of that year that entitle him or her to continue receiving unemployment compensation benefits beyond the end of the benefit year.

(3) Exhaustion of Benefits. Benefits shall be terminated for the contract unit seven days from the last week ending date for which the primary enrollee receives the maximum unemployment compensation benefits available to him or her under M.G.L. c. 151A, §§ 30, 30A and 30B.

(4) Failure to Meet Other Eligibility Requirements. Benefits for the contract unit shall be terminated immediately if the primary enrollee fails to satisfy the requirements set forth in 117 CMR 9.03(3)(b) or (c). For any other member of the contract unit, membership in the contract unit shall be terminated immediately if that enrollee fails to satisfy the requirements set forth in 117 CMR 9.03(2)(b) or (c).

(5) Misrepresentation. Benefits shall be terminated or reduced for the contract unit retroactive to the first day of eligibility for benefits as defined in 117 CMR 9.07(2) if the primary enrollee

(a) misrepresents any information on his or her application which, had the information been correctly represented,

1. would have led to a denial or reduced level of benefits to the primary enrollee; or
2. would have led to the denial of membership for any other member of the contract unit. Such membership shall be terminated retroactive to the first day of eligibility for benefits as defined in 117 CMR 9.07(2) and 9.07(4).

(b) misrepresents any information during his or her appeals process which, had the information been correctly represented, would have led to a denial or reduced level of benefits to the primary enrollee and to all other member of the contract unit.

(6) Failure to Notify of Changed Circumstances. Benefits shall be terminated for the contract unit retroactive to the day on which the primary enrollee failed to satisfy the requirements of 117 CMR 9.03(3)(d) if the change in circumstances is such that the primary enrollee is no longer eligible for benefits under 117 CMR 9.09.

(7) Voluntary. Benefits for the contract unit shall be terminated immediately if the primary enrollee submits to the Department a signed, written statement that he or she wishes to terminate benefits. For any other member of the contract unit, membership in the contract unit shall be terminated immediately if the primary enrollee submits to the Department a signed, written statement that he or she wishes to terminate enrollment for that enrollee.

(8) Failure to Cooperate with Audit. Benefits may be terminated for the contract unit after written notice by the Department if the primary enrollee, subsequent to a determination of eligibility, fails to provide information as requested by the Department in order to verify the eligibility of any member of the contract unit.

(9) Failure to Cooperate with the Department. Benefits may be terminated for the contract unit if the primary enrollee fails to cooperate in any manner with the Department.

(10) Failure to Comply with any Statutory or Regulatory Requirement. Benefits may terminate for the contract unit if the primary enrollee fails to comply with any requirement under 117 CMR 9.00. or any statutory requirement governing the Medical Security Plan.

9.09: continued

(11) Obligation of Enrollee upon Termination. The enrollee shall immediately repay to the Department, all benefits received by any member of the contract unit, which have been paid by the Department for services rendered after the date of termination as set forth in 117 CMR 9.09.

9.10: Grievance

(1) Decisions That May Be Grieved. An applicant or enrollee may file a grievance with the Department if the applicant or enrollee is dissatisfied with any decision, action, or inaction of the Department that directly effects the person and is related to the receipt of benefits under 117 CMR 9.10.

(2) Grievance Process. An applicant or enrollee may initiate a grievance by filing a written statement with the Department. The statement must state the reason the applicant or enrollee is aggrieved. If a written statement fails to state the basis for the grievance, the Department shall respond in writing stating the need for more information. If the grievant fails to respond to such notice within 21 days after the date of such notice, the grievance shall be denied.

All grievances must be filed within 14 days after the Department's decision, action, or inaction which forms the basis of the grievance. If a grievance is filed due to the inaction of the Department, the grievance must be filed within 14 days after the applicant or enrollee could have reasonably expected the Department to act.

The Department shall seek to resolve all grievances in an informal manner that responds to the needs of all affected parties. Once a proper grievance is filed, the Department shall respond to the grievance in writing within a reasonable time.

9.11: Appeal

(1) Decisions That May Be Appealed. An applicant or enrollee may file an appeal with the Commissioner under the following circumstances:

(a) An applicant whose application for benefits is denied in whole or in part may appeal the decision.

(b) An enrollee whose benefits are terminated or whose benefits are reduced may appeal the determination.

(2) Limitations to Appeals. Under no circumstances may an appellant raise upon appeal any issues relevant to the appellant's eligibility for unemployment compensation. The sole issue relating to unemployment compensation that may be raised upon appeal under 117 CMR 9.11 is whether the appellant is actually receiving or received unemployment compensation benefits.

No appeal shall be considered unless the appellant first sought review of the decision through the grievance process. The issues that may be raised on appeal shall be limited to those that are related to or arise from issues that were first raised in the grievance process.

All appeals must be made within 14 days after the date of the Department's response to the enrollee's or applicant's grievance.

(3) Appeals Process

(a) Initiation. An appellant may initiate a request for appeal by filing a written request with the Commissioner. The request must state the reason the applicant is aggrieved. If a written request for an appeal fails to state the basis for the appeal the Commissioner or appointed designee shall respond in writing stating the need for more information. If the appellant fails to respond to such notice within 21 days after the date of such notice, the request for appeal shall be denied.

(b) Administrative Review. The Commissioner or appointed designee shall review the request for an appeal and any documents or evidence related to the request.

1. If the Commissioner or appointed designee determines that the request for appeal raises genuine issues of material fact, the Commissioner or appointed designee shall issue an order referring the matter to a hearing officer for a fair hearing on the matter. The fair hearing shall be held in the manner set forth in 117 CMR 9.11(3)(c).

9.11: continued

2. If the Commissioner or appointed designee concludes that the evidence before him is insufficient to determine whether the request for appeal raises genuine issues of material fact, the Commissioner or appointed designee may undertake an investigation to obtain such additional evidence as may be necessary to make such a determination. Such investigation may include, without limitation, a request for additional information from the appellant.

3. If the Commissioner or appointed designee determines that the appeal raises only issues of law or departmental policy, the Commissioner shall grant or deny such appeal based on the appropriate law or departmental policy. The appellant shall be notified promptly in writing when a final decision is reached. The notice shall include a statement of reasons for the decision.

4. If the Commissioner or appointed designee determines that the appeal is untimely, has been voluntarily withdrawn, or raises issues other than those that may be decided upon appeal, the request for an appeal shall be denied and the appellant shall be notified in writing that the appeal has been dismissed. The notice shall include a statement of reasons for the dismissal.

(c) Fair Hearing. All fair hearings authorized by 117 CMR 9.11(3)(b)1. shall proceed according to the provisions of 801 CMR 1.02 and 1.03. Such proceedings shall also be governed by the following rules:

1. The appellant shall bear the burden of proving that he or she is eligible for benefits under 117 CMR 9.11.

2. Upon conclusion of the fair hearing, the hearing officer shall forward to the Commissioner or appointed designee a recommended decision. The recommended decision shall include a statement of the issues raised upon appeal, a summary of the evidence, a summary of factual and legal findings, a conclusion, and a proposed order. The Commissioner or appointed designee may adopt, modify, or order reconsideration of the hearing officer's recommended decision.

3. The appellant shall be promptly notified in writing of the decision after a final decision is reached. The notification shall contain a summary of the reasons for the decision and information regarding possible judicial review of the decision under M.G.L. c. 30A, §14. The Department shall implement the final decision with reasonable promptness.

9.12: Severability

If any section or portion of any section of 117 CMR 9.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 117 CMR 9.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

REGULATORY AUTHORITY

117 CMR 9.00: M.G.L. c. 118F, § 6(a).

directed to file with the chairman of said committees an updated report detailing the most recently available statement of the actual balance then credited to the commonwealth's account in the Unemployment Insurance Trust Fund together with a revised statement of the actual balance then projected to be credited to the commonwealth's account during such year.

History—

Amended by 1990, 177, §§ 260—262, approved, with emergency preamble, Aug 7, 1990.

Editorial Note—

The 1990 amendment, by § 260, substituted "commissioner" for "director", in each instance it appears, by § 261, substituted "commissioner's" for "director's", in two places, and by § 262, substituted "Unemployment Trust Fund" for "unemployment trust fund", in two places, and substituted "Unemployment Insurance Trust Fund" for "unemployment insurance trust fund".

Acts 1992, ch. 118, §§ 53, 54, entitled "An Act relative to restoring solvency to the unemployment insurance trust fund" which was approved, with emergency preamble, July 14, 1992, provide as follows:

SECTION 53. In addition to the information required to be provided in section fourteen F of chapter one hundred and fifty-one A of the General Laws, the commissioner of the department of employment and training shall include in each quarterly report a five year projection, using applicable schedules, for the private contributory system which indicates for each calendar year estimated contributions, benefit payments, trust fund balance, total estimated interest owed to the federal government as of September thirtieth of the calendar year, interest to be collected by employers through the surcharge imposed under section fourteen J of said chapter one hundred and fifty-one A on an accrued basis, and the aggregate dollar amount of FUTA employer credit reduction that will be applicable in the calendar year. Such quarterly reports shall include the economic assumptions on which the projections are based including the total covered payroll, taxable payroll, covered employment, the effective tax rate on taxable wages for the applicable schedule which shall include the solvency assessment, the taxable wage proportion, the total unemployment rate, and the total insured unemployment rate. The quarterly reports shall be audited by a private, independent organization by December thirty-first of each year.

SECTION 54. The report of the commissioner of the department of employment and training provided each October fifteenth shall include a recommendation regarding the amount of contributions necessary for the succeeding calendar year to achieve a positive trust fund balance, at reasonable increments, by December thirty-first, nineteen hundred and ninety-five and ninety-six and shall include a statement, if applicable, that the total contributions for the succeeding calendar year may exceed one and seventy-five hundredths percent of total wages in such year and any recommendations to prevent the same.

§ 14G. Unemployment Health Insurance Contribution; Medical Security Contribution; Employees Excluded; Deductions Allowed; Computation of Contribution; Rate Review Board; Penalties; Hearing and Appeal; Notice of Eligibility for Health Insurance Coverage.

(a) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the commissioner prescribes for the contribution required by section fourteen, an unemployment health insurance contribution computed by multiplying the wages paid its employees by twelve hundredths of one per cent.

(b) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the commissioner prescribes for the contribution required by section fourteen,

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